2014 CMS and ONC Certified EHR Technology (CEHRT) Flexibility Rule Frequently Asked Questions

The following questions and responses explain some of the key provisions of the 2014 CMS and ONC Certified EHR Technology (CEHRT) Flexibility Rule.

1. **The rule states that only providers who have not been able to fully implement 2014 Edition CEHRT due to delays in 2014 Edition CEHRT availability are able to use the flexibility options. What does that mean?**

   Response:
   CMS stresses the delay in 2014 Edition CEHRT availability must be attributable to the issues related to software development, certification, implementation, testing, or release of the product by the EHR vendor which affected 2014 CEHRT availability, which then results in the inability for a provider to fully implement 2014 Edition CEHRT.

   Examples that do **not** count as delays in availability:

   - **Financial Issues**- Providers that did not fully implement 2014 Edition CEHRT due to financial issues, such as the costs associated with implementing, upgrading, installing, testing, or other similar financial issues, would not be able to use the options.
     - Providers facing significant cost concerns relating to things like insufficient internet access and insurmountable barriers to obtaining infrastructure (broadband access) can apply for a hardship exception.
   - **Difficulty Meeting Measures-** Issues related to the meaningful use objectives and measures do not constitute an inability to fully implement 2014 Edition CEHRT. These providers who simply cannot meet one or more measures cannot use the options and must attest to their stage of meaningful use using 2014 Edition CEHRT as originally intended (see question 7 for limited exception for Stage 2 Summary of Care).
   - **Staffing Issues-** Staff changes and turnover are insufficient rationales for a provider to use the options. CMS considers staff turnover and changes, as well as any other similar situations, to be issues frequently encountered in the normal course of business and therefore insufficient grounds for a provider to use the options.
   - **Provider Delays-** Situations stemming from providers' inactions or delays in implementing 2014 Edition CEHRT are not sufficient to use one of the options. These situations include providers waiting too long to engage a vendor or a provider's inability or refusal to purchase the requisite software update.

   See section 79 FR 52921 of the rule for more information.

2. **Can providers mix and match measures and objectives from 2013 Stage 1, 2014 Stage 1, and Stage 2 so that they are able to successfully attest?**

   Response:
   CMS did not propose the ability to mix and match between the meaningful use objectives and measures and the CQMs for different years and stages for the following reasons:

   - Meaningful use objectives and measures are designed to match specific editions of CEHRT. These CEHRT Editions are required to support specific meaningful use objectives and measures as well as the CQMs required for the program.
   - The complexity of the systems required to support attestation and CQM submission would mean CMS would be unable to operationalize that flexibility in time to allow

providers to attest for an EHR reporting period in 2014 if CMS allowed for additional flexibility in this manner.

Therefore, providers must attest to the required set of objectives and measures applicable for the CEHRT option they choose, as well as the CQMs that relate to that option.

If a provider chooses the 2013 Stage 1 objectives and measures they must attest to the CQMs using the reporting requirements specified for 2013. Providers selecting this option for the use of CEHRT have the ability to electronically report the 2014 CQMs to quality programs such as PQRS and IQR separately for participation in those programs should they so choose.

See section 79 FR 52929 of the rule for more information.

3. How are CQMs affected by this rule?

Response:
CQMs applicable for use in 2013 are not allowed to be decoupled from the 2013 Stage 1 objectives and measures, nor can the 2014 CQMs be separated from the 2014 Stage 1 objectives and measures or the Stage 2 objectives and measures.

However, providers are already permitted under the EHR Incentive Programs to use a different reporting period for the CQMs for 2014 than for the objectives and measures of meaningful use under §495.6. Therefore, providers could use an earlier quarter of data if they use the option allowing for attestation to the 2013 Stage 1 objectives and measures using 2011 Edition CEHRT or a combination of 2011 and 2014 Edition CEHRT.

Example: *If a provider chooses to use a combination of 2011 Edition and 2014 Edition CEHRT and attests to the 2013 Stage 1 meaningful use objectives and measures, that provider may use the 2011 Edition CEHRT for 60 days of a 90-day reporting period (and 2014 Edition CEHRT for 30 days of the reporting period), and only report on CQMs for that 60-day period.*

CMS is allowing providers to use a subset of data for the CQMs in use for 2013 for any period of time in which the 2011 Edition CEHRT was in place if they are attesting to the 2013 Stage 1 objectives and measures using a combination of 2011 Edition and 2014 Edition CEHRT. CMS believes this will help providers that are seeking to use a combination of 2011 Edition and 2014 Edition CEHRT that may no longer have the same CQMs available in their 2014 Edition CEHRT.

See section 79 FR 52929 of the rule for more information.

**Note: Providers are permitted under the EHR Incentive Programs to use a different reporting period for the CQMs for 2014 than for the objectives and measures of meaningful use under §495.6.*

4. When do providers have to attest to the 2014 certification flexibility options?

Response:
Eligible professionals have until February 28, 2015—two months after the last day of the calendar year—to attest to demonstrating meaningful use in 2014.

The last day for eligible hospitals and critical access hospitals to attest to fiscal year 2014 is November 30, 2014.

Eligible professionals and eligible hospitals in their first year can choose any continuous 90 days of the 2014 calendar year to participate, and those in their second year and beyond can choose any three-month quarter in 2014.

Successfully demonstrating meaningful use for any reporting period in 2014 would allow these providers to avoid the 2016 payment adjustment.

See section 79 FR 52924 of the rule for more information.

5. What is the significance of the October 1, 2014 deadline?

Response:
The October 1, 2014 deadline is the date by which eligible professionals who have not demonstrated meaningful use in a prior year must attest in order to avoid the 2015 payment adjustment. First time participants would otherwise be subject to the 2015 payment adjustment because they did not meet meaningful use in 2013. This does not apply to brand new providers (who have just started practicing) who have an automatic 2 year exemption from the payment adjustments.

6. How will this rule affect incentive payments?

All new participants in 2014 may earn an incentive payment for 2014 and avoid the 2016 payment adjustment by successfully demonstrating meaningful use for an EHR reporting period of any continuous 90 days in 2014. Even if these providers do not meet the early attestation deadline and therefore receive a payment adjustment in 2015, they may still earn an incentive payment for meeting meaningful use for an EHR reporting period in 2014 by starting their 90-days by October 3.

This is especially important because 2014 is the last year Medicare eligible professionals can begin participation and receive incentive payments. If they continue to achieve meaningful use, they can earn incentive payments for 2015 and 2016 participation.

Eligible professionals who start participation in 2015 will not be eligible to receive incentive payments, but can avoid payment adjustments.

See section 79 FR 52924 of the rule for more information.

7. Is there additional guidance for how providers should use the combination flexibility option?

Response:
CMS does not specify whether a provider must use 2011 Edition CEHRT or 2014 Edition CEHRT for a certain amount of time during the EHR reporting period, whether a certain amount of modules in one CEHRT edition or another is required, or whether a certain number of provider settings must have one CEHRT edition over another.

CMS expects there will be significant variation among practices based on the type of software used, the complexity of a provider's total systems, and the overall implementation timeline for 2014 Edition CEHRT installation.

Providers who use a combination of 2011 Edition and 2014 Edition CEHRT will enter a certification number into the Registration and Attestation System, and based on that number, will

be presented with a choice of 2013 Stage 1 objectives and measures, or 2014 Stage 1 objectives and measures (and Stage 2 objectives and measures if they were previously scheduled to begin Stage 2).

Reporting requirements for providers who use a combination of 2011 Edition and 2014 Edition CEHRT:

- Those who choose to attest to the 2013 Stage 1 meaningful use objectives and measures will report on only those objectives and measures and attest to the CQMs that were applicable for 2013.
- Those who choose to attest to the 2014 Stage 1 meaningful use objectives and measures will report on only those objectives and measures and submit the 2014 CQMs through attestation or electronic reporting.
- Those who choose to attest to Stage 2 objectives and measures will attest to only the Stage 2 objectives and measures and submit the 2014 CQMs through attestation or electronic reporting.

See section 79 FR 52918 of the rule for more information.

8. If providers practice in multiple locations with different CEHRT Editions, how can they take advantage of the flexibility options?

Response:
Eligible professionals who practice in multiple locations which have been unable to fully implement 2014 Edition CEHRT for an EHR reporting period in 2014 due to CEHRT availability delays may attest using the options outlined in thefinal rule.

If an eligible professional uses different editions of CEHRT at multiple locations, he or she may choose to use the alternate CEHRT option that is best applied for his or her patient encounters across all locations during the EHR reporting period. These eligible professionals should then use the data from all patient encounters which occur at a location equipped with any edition of certified EHR technology, just as the eligible professional would use the patient data from all locations equipped with CEHRT to meet meaningful use in any other year.

Exception: *If over 50 percent of the eligible professional's patient encounters during the EHR reporting period occur at locations equipped with 2014 Edition CEHRT which has been fully implemented, the eligible professional would* ***not*** *be eligible to use the flexibility options in this final rule, and should therefore limit their denominators to only those patient encounters in locations equipped with fully implemented 2014 Edition CEHRT.*

See section 79 FR 52923 of the rule for more information.

9. What if a provider has 2014 Edition CEHRT, but is not able to meet the threshold for the second measure of the Summary of Care objective due to lack of recipients with 2014 Edition CEHRT?

CMS recognizes that the second measure of the Stage 2 Summary of Care objective requires electronic transmission using CEHRT, which implies that the recipient or intermediary is able to receive the summary of care document in the standard required for transmission.

This means referring providers may not be able to meet the summary of care measure in 2014 if receiving providers they frequently work with have not upgraded to 2014 Edition CEHRT.

CMS therefore believes a limited exception is warranted for providers who could not meet the threshold for the Stage 2 summary of care measure because the recipients of the transitions or referrals were impacted by issues related to 2014 Edition CEHRT availability delays and therefore could not implement the functionality required to receive the electronic summary of care document.

Flexibility option: *CMS considers the inability to fully implement to extend to those providers for the summary of care document measure at 42 CFR 495.6 (d)(14)(ii)(B) for eligible professionals and (l)(11)(ii)(B) for eligible hospitals and CAHs. A referring provider under this circumstance may attest to the 2014 Stage 1 objectives and measures for the EHR reporting period in 2014.*

Note: The referring provider must retain documentation clearly demonstrating that they were unable to meet the 10 percent threshold for the measure to provide an electronic summary of care document for a transition or referral for the reasons previously stated.

See section 79 FR 52921 of the rule for more information.

10. What will the audit process include for providers who have not fully implemented 2014 CEHRT?

CMS will follow standard guidelines used for CMS programs with audit provisions, including auditing providers based on a random selection process, as well as selection based on key identifiers such as prior audit failure or known incidence of fraud. Providers will not be targeted by provider type, location, stage of meaningful use, or participation year.

Therefore, although CMS acknowledges that the flexible options for CEHRT may modify a provider's timeline for implementation of meaningful use, a provider attesting to Stage 2 using the 2014 Edition CEHRT is no more likely to be subject to an audit than any other provider attesting in 2014.

To alleviate concerns about required documentation for a potential audit, CMS will provide guidance to auditors relating to the 2014 CEHRT Flexibility final rule and the attestation process. Auditors will be instructed to work closely with providers on the supporting documentation needed that is applicable to the provider's individual case.

Audit determinations are finalized on a case by case basis, which allows CMS to give individual consideration to each provider. CMS believes that such case-by-case review will allow us to adequately account for the varied circumstances that may result in a provider selecting a different CEHRT option.

See section 79 FR 52918 of the rule for more information.